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Re-Thinking *Herczegfalvy*: The ECHR and the Control of Psychiatric Treatment

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1 Introduction: Why Herczegfalvy?

The decision of the ECtHR in *Herczegfalvy* v. *Austria*,[1] has defined the approach of the ECtHR to standards of care and treatment in psychiatric facilities for almost twenty years. The case has created considerable difficulties in bringing litigation under the ECHR on these matters, with the result that while a burgeoning jurisprudence now exists on detention in psychiatric institutions under article 5,[2] the Court has had very little to say about care and treatment within institutions under articles 3 and 8.

A reading of *Herczegfalvy* serves as a reminder of how views of people with mental disability[3] and their treatment have changed in the subsequent decades. In part, this involves categorisation of facts. The Court in *Herczegfalvy* considered the handcuffing of the applicant to a security bed for more than two weeks as a matter of medical treatment. It would now be viewed as restraint, and that is how it is considered in the re-drafting. Other issues concern developments in the law. The jurisprudence of the ECtHR has itself of course progressed, and no doubt this would result in different arguments arising, were *Herzcegfalvy* to be litigated today. It is difficult to believe now, for example, that Mr Herczegfalvy would not have included a number of challenges to the guardianship régime to which he was subjected, based on the Court's decision in *Shtukaturov v. Russia*.[4] *Herczegfalvy* further predates the influence of key human rights instruments in the area. Within the Council of Europe, the Committee for the Prevention of Torture (CPT) did not publish its standards for psychiatric establishments until 1998,[5] and since that time, their country reports have been extraordinarily influential in setting European norms of service provision. Further, the Committee of Ministers has published recommendations concerning the protection of the human rights and dignity of persons with mental disorders in 2004,[6] and concerning the legal protection of incapable adults in 1999.[7] Internationally, an array of instruments has been adopted. The most notable of these is the new United Nations Convention on the Rights of Persons with Disability

[1] ECtHR, 24 September 1992, (A/244) (1993) 15 EHRR 437. Hereinafter '*Herczegfalvy*'.
[2] For a summary of this case law, see P Bartlett, O Lewis and O Thorold, *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff, 2007), chapter 2.
[3] In this paper, 'mental disability' is taken to be taken broadly as referring to people with psychosocial disabilities (mental health problems), learning or developmental disabilities, and mental disabilities associated with the end of life such as dementia.
[4] ECtHR, 27 June 2008.
[5] Originally as a part of their 8th General Report, CPT/Inf (98) 12; reprinted periodically since that time, most recently as CPT/Inf/E (2002) 1 - Rev. 2009.
[6] Rec(2004)10.
[7] R(99)4.

(CRPD),[8] which was passed by the General Assembly in 2006 and entered into force in May, 2008. Like the ECHR, the CRPD is a binding international treaty. All States Parties to the CRPD are required to submit periodic reports to a committee that comments publicly on them, and for States Parties to the optional protocol, the committee considers individual complaints, much as a court would. Non-compliance with the CRPD will therefore be visible, as is non-compliance with the ECHR. This raises interesting and problematic prospects of conflicts between the two régimes.

The approach in *Herczegfalvy* is therefore ripe for reassessment. The re-drafting focuses on issues of treatment and conditions in psychiatric facilities, the issue for which the case remains a landmark, but a number of the issues raised below apply to the Court's approach to mental health law more broadly – most notably, the need for the Court to ensure that clear and meaningful substantive standards are in place in domestic law. Indeed, *Herczegfalvy* itself was primarily a case about detention under article 5. These issues are not included in the re-drafting since they have faded into obscurity, although some aspects are mentioned in passing in part 3 of this paper. The redrafting does take into account the developments in European and international law, and the developing case law of the ECtHR. The temptation to launch into entirely new lines of argument (as, for example, a challenge to the guardianship law based on *Shtukaturov*) has been resisted. The facts and domestic law have been taken as they were twenty years ago, when the case arose. Some factual material required for the new analysis is not contained in the existing reasons of the Court and Commission, and the application of the proposed new law to the factual situation of the case is consequently problematic.

2 Substantive Overview: The ECtHR and Mental Disability

The Need for Substantive Clarity

In dealing with cases of persons with mental disabilities, the ECtHR has been relatively good on procedural justice, but not nearly so strong on substance. The Court's treatment of Article 5 provides a clear example of this. The Court has been quite good at insisting on the provision of appropriate procedural controls and review hearings, and defining the terms of those processes, but its approach to substance has been abstract. The *Winterwerp* criteria require that a 'true mental disorder' be present, of a severity 'warranting compulsory confinement',[9] and the Court has elsewhere made it clear that detention under Article 5 may be justified for reasons of dangerousness or in the interests of the individual's health.[10] The Court has delegated further refinement of these requirements to States Parties, however, referring merely to the general requirement originating in *Sunday Times v. the United Kingdom* that a citizen 'must be able - if need be with appropriate advice - to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action may entail.'[11]

The *Sunday Times* language provides an appropriate standard, although the implied characterisation of a person with mental disability, be it a psychosocial disability (mental health problem) or a learning disability, as a person rationally considering the outcome of conduct and seeking legal advice may be counterintuitive in some of the factual contexts where the law will be applied. What is at least as important is that the persons administering the law will have sufficient guidance to ensure consistency in decision-making. Without that clarity, the decision regarding compulsory admission or compulsory treatment will depend to an unacceptable degree on the

[8] United Nations General Assembly, A/61/611, 6 December 2006.
[9] See ECtHR, *Winterwerp v. the Netherlands*, 24 October 2979, (A/33) (1979-80) 2 EHRR 387, para. 39.
[10] ECtHR, *Hutchinson Reid v. the United Kingdom*, judgment 20 May 2003, (2003) 37 EHRR 9, para. 52.
[11] ECtHR, *Sunday Times v. the United Kingdom*, 26 April 1979, (1979) 2 EHRR 245, para. 49.

professional staff (sometimes a doctor alone, sometimes a doctor with other professionals) assessing the individual. That will in turn often depend on who is on duty when the individual is apprehended: detention, enforced treatment, and human rights become a lottery.

The difficulty is that domestic law often does not meet that standard. The current English law will serve as an example. Detention of an individual may occur on the grounds that

> (a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
>
> (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.[12]

This language mirrors the ECRH jurisprudence admirably, but the section provides no meaningful standard: different practitioners might well apply vastly different standards while remaining within the statutory language, with consequently inconsistent results as to detention.[13]

Notwithstanding the routine citation of the *Sunday Times* standard, the ECtHR does not necessarily criticise legislation that is remarkably weak on its substantive specificity. In *Rakevich v. Russia*, after citing the *Sunday Times* standard, the Court did not criticise the standard that 'the mental disorder is severe enough to give rise to a direct danger to the person or to others', noting the practical difficulty of articulating dangerousness specifically in legislation.[14] The difficulty is that dangerousness is very difficult to predict, and when relying simply on their instincts, doctors vastly over-predict dangerousness, resulting in the detention of large numbers of people who would not actually have been the cause of significant harm.[15] The standard also begs the question of how dangerous is dangerous? In *Rakevitch* itself, the government's position was that the applicant was in an acute psychotic condition accompanied by confusion, fear, and psychomotor excitation.[16] While the government thus makes a coherent claim that the applicant was mentally unwell, there is no suggestion that she was in any way violent. Was she a 'direct danger'? It seems at best doubtful, but how is one to know, given this standard? The ECtHR goes on to find that the fact that all detentions were subject to judicial review as a 'substantial safeguard against arbitrariness', but this is, with respect, nonsense. Why would an unclear standard protect against arbitrariness, merely because the unclear standard was administered by a court?

Even more startling is the case of *HL v. the United Kingdom*.[17] In that case a person lacking the capacity to decide on his own psychiatric admission was detained in a psychiatric hospital. The detention was outside the terms of mental health legislation, and was held ex post facto to rely instead on the common law doctrine of necessity. The Court found that the substantive criteria for

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[12] Mental Health Act 1983 (as amended), s 2. The English law regarding enforced psychiatric treatment is even weaker, with compulsion of involuntary patients left entirely to the discretion of the clinician for the first three months of admission, except in cases of psychosurgery and ECT: see Mental Health Act 1983, s 57, 58, 63. No criteria are provided in the Act for the exercise of this discretion.

[13] See further Jill Peay, *Decisions and Dilemmas: Working with Mental Health Law* (Hart 2003), which empirically analyses divergent decision-making in the context of the English act.

[14] ECtHR, *Rakevich v. Russia*, 28 October 2003, para. 32.

[15] For an overview of the literature regarding prediction of dangerousness in a psychiatric context, see J Monahan, 'A Jurisprudence of Risk Assessment: Forecasting Harm among Prisoners, Predators and Patients', *Virginia Law Review*, 92 (2006) 392-435, esp at 405-427; M Grann et al, *Psychiatric Risk Assessment Methods: Are Violent Acts Predictable? A Systematic Review*, (SBU, 2005).

[16] *Rakevich*, para. 23; see further para. 10-11 concerning the facts.

[17] ECtHR, 5 October 2004, (2005) 40 EHRR 32.

this detention were '(i) there must be a necessity to act when it is not practicable to communicate with the assisted person and (ii) that the action taken must be such as a reasonable person would in all circumstances take, acting in the best interests of the assisted person.'[18] There was no particular history to these criteria: the *HL* case itself was the first time that they had been formulated in this way, and to suggest that they were established law relied upon by the hospital in this case is a judicial fiction. The criteria are also astonishingly open-ended, offering very little guidance to practitioners as to what they ought to do in practice.

The ECtHR did find a violation of Article 5 based on the unlawfulness of the criteria, and there is, just possibly, some indication that the substance of the criteria might have been insufficient.[19] The focus of the Court's concern, however, was once again not on the substance, but on the process: who should be allowed to detain the individual, and following what assessments, and whether a representative for the patient needed to be appointed.[20] There is no doubt that process is important; but it is not a substitute for proper substantive standards that provide meaningful direction to those administering the legislation.

Certainly, it remains within the jurisdiction of States Parties in the first instance to regulate their own affairs; but in the same way that we would not allow religious persecution merely because the procedures of domestic legislation were followed, so we must insist on a certain level of substance for the law relating to people with mental disabilities. Certainly, as the Court is frequently at pains to point out, legislative drafting in this area can be a challenging exercise, but the Court can insist on a significantly higher standard than is the case at present. Consider, for example, the following example drawn from Ontario, Canada. Like the legislation in *Rakevich*, it is designed to admit people who are dangerous to themselves or others, or who are unable to care for themselves; unlike the legislation in *Rakevich*, it is much clearer as to what practitioners ought to consider in reaching their decision:

> Application for psychiatric assessment
> 15.(1)Where a physician examines a person and has reasonable cause to believe that the person,
> (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
> (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
> (c) has shown or is showing a lack of competence to care for himself or herself,
> and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
> (d) serious bodily harm to the person;
> (e) serious bodily harm to another person; or
> (f) serious physical impairment of the person,
> the physician may make application in the prescribed form for a psychiatric assessment of the person. [21]

[18] *HL,* para. 117.
[19] *HL,* para. 119. The Court seems not to make a definitive finding on this point.
[20] *HL*, para. 120.
[21] Mental Health Act, R.S.O. 1990, c. M.7, s. 15 (1); 2000, c. 9, s. 3 (1). Ontario also has provisions relating to detention of relapsing patients: see s 15(1.1). The Ontario legislation regarding compulsory treatment, while more relevant to *Herczegfalvy*, is too long to be discussed in this paper: see Health Care Consent Act 1996, S.O. 1996, c. 2, sch A; see further P Bartlett, 'English Mental Health Reform: Lessons from Ontario?', *Journal of Mental Health Law* (2001) 27, available online at http://eprints.nottingham.ac.uk/144/.

The drafting remains problematic, based as it is on predictions of dangerousness which are inherently imprecise; but the section of the Ontario Mental Health Act provides remarkably clearer guidance on what the professional should consider, and what the conditions precedent are to detention. The Court can, and should, insist on a significantly improved standard of drafting.

This discussion is relevant for the Court's approach to mental disability law generally, but also to *Herczegfalvy* in particular. In *Herczegfalvy*, the Court begins its jurisprudence that 'as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading.'[22] While that position has its merits, it begs the question of how 'therapeutic necessity' is to be understood. A considerable part of the present redrafting of that case is an attempt to articulate how, as a matter of ECHR jurisprudence, States should be expected to approach that.

The ECHR and the CRPD: Conflicts of Laws

The introduction of the CRPD has the potential significantly to alter the legal and human rights landscape for persons with disabilities, including persons with mental disabilities. Currently, all member states of the Council of Europe except Liechtenstein, Moldova, and Switzerland plus the European Union, have signed the CRPD, and 35 CoE member states have ratified it. The CRPD Committee will report publicly on States' compliance with the Convention, and for countries ratifying the first optional protocol, the CRPD Committee will adjudicate complaints from individuals. Currently, 28 members of the Council of Europe have signed this protocol, and 23 ratified it.[23] Unlike many of the previous international law instruments to mental disability, this is binding international law, with an enforcement mechanism attached.

It is of course a new Convention, and the Committee created to interpret, oversee and enforce it has been fully functional only since the autumn of 2010, so definitive interpretations of the Convention's terms are not yet available. Much of the CRPD concerns positive obligations that services be made available for persons with disabilities, and prohibiting discrimination in service provision on the basis of disability. Most significantly for people with mental disabilities, it provides rights to community living and community integration, and many of the umbrella services that make that possible: housing, education, social services and employment, for example. These issues can be perceived as separate from and lying alongside traditional areas of ECHR jurisprudence: there is no necessary conflict. Other areas, such as the right to freedom of expression in Article 21 of the CRPD, do overlap with ECHR rights, but will generally be consistent with the direction of ECHR jurisprudence. While practical conflicts may of course arise as different decision-making bodies interpret similar but non-identical provisions, it seems unlikely that there will be significant difficulties of coexistence. In some areas, however, the terms of the Convention, along with some of the early comments made about it, would suggest overlap with ECHR jurisprudence in ways that are quite different to that jurisprudence, and potentially inconsistent with it.

Article 14(1)(b) of the CRPD, for example, provides in part that 'the existence of a disability shall in no case justify a deprivation of liberty.' While the matter is not entirely free from doubt, the UN High Commissioner for Human Rights has taken the view that this does not merely mean that disability may not be the sole justification for deprivation of liberty, but that it may not be a factor at all. [24] Equally challenging is the High Commissioner's view that the insanity defence, based as it is on the mental disability of the accused, must be abolished in its current form.[25]

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[22] *Herczegfalvy*, para. 82.

[23] A table of signatories and ratifications for the convention and the protocol may be found at http://www.un.org/disabilities/countries.asp?id=166, accessed 16 November 2012.

[24] Annual report of the High Commissioner for HumanRights to the General Assembly. A/HRC/10/49, presented 26 January 2009, para. 48-9. See also UN, Office of the High Commissioner for Human Rights

Article 12 of the CRPD governs equal recognition before the law, and provides that persons with disability enjoy legal capacity on an equal basis with others in all aspects of life. Legal mechanisms, with appropriate safeguards, must be put into place to ensure that they may realise this right, and restrictions are placed on measures which affect the exercise of this legal capacity. It is not entirely clear whether the CRPD will prohibit any kind of incapacity determination, opting for a system of universal capacity buttressed by supported decision-making, or whether some limitations to the exercise of legal capacity will be permitted,[26] but certainly issues of guardianship and capacity determination will be much more closely limited than is the case in many Council of Europe member states. The ECtHR has itself started to address some of these issues from a rather different direction, most notably in *Shtukaturov v. Russia*[27] and, concerning the right to vote by people under guardianship, *Kiss v. Hungary*.[28]

Article 25 of the CRPD provides that medical treatment is to be given based on 'free and informed consent', and Article 17 provides a right to respect for 'physical and mental integrity on an equal basis with others.' Certainly for people with the actual capacity to make the treatment decision in question, it seems likely that the CRPD will be very hesitant to deprive them of the right to consent to medical treatment. In particular, it seems likely that it will prohibit systems that allow for the compulsory treatment of people with mental disabilities in circumstances where people with physical ailments of comparable seriousness would be permitted by law to refuse treatment. It is likely to be the case, as reflected in the redrafted version of *Herczegfalvy* attached, that life-saving treatments of detained persons will still be permitted by the CRPD, if such treatment would be imposed upon persons who do not have such a disability.[29] Article 17 and the relevant portion of Article 25 explicitly refer to integrity and consent rights on the same basis as to non-disabled persons, suggesting that the concern is on non-discrimination. It is when different rules apply to people with disabilities that Article 25 will bite.

The immediate question is how far the ECtHR should take into account the developing law surrounding the CRPD. Certainly, there is an argument that the two systems are separate, and each should be allowed to develop in its own way. This is legally correct, and, at least in some cases, does not pose a theoretical problem. If the CRPD Committee takes the view, for example, that mental disability may not form any part of criteria for detention, no direct conflict would be created with the ECHR, as Article 5(1)(e) does not oblige states to detain persons of unsound mind, but merely permits them to do so. The effect would be that the part of Article 5(1)(e) of the ECHR relating to persons of unsound mind would in practice become an irrelevance for states party to the CRPD. While this would be doctrinally consistent, it would be a surprising and disappointing result, as it would leave the ECtHR, the most important regional human rights court in the world, with nothing to say about an important human rights concern.

'Persons with Disabilities' Dignity and Justice for Detainees Week, Information Note No. 4, (2008) p. 2. Available at http://www.ohchr.org/EN/UDHR/Documents/60UDHR/detention_infonote_4.pdf. Accessed 26 July 09. For a consistent view, see interim report of the UN Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, published by UN General Assembly, A/63/175 (2008), para. 64.

[25] Annual report, A/HRC/10/49 at para. 47.

[26] Regarding Article 12, see A. Dhanda, 'Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?', *Syracuse J Int'l L & Comm* 34 (2007), 429-462.

[27] Application No 44009/05, judgment of 27 June 2008.

[28] Application no 38832/06, judgment of 20 August 2010.

[29] See paragraph 93 of re-drafted judgment.

When the conventions place conflicting duties onto States that are party to both conventions, there are potential problems. If the ECHR were to require compulsory treatment of an individual, for example, in situations where the CRPD would prohibit it, States Party would be left in an impossible position. It is fair to expect both treaty bodies to work to ensure that this does not occur.

Most cases before the ECtHR will fall into neither of these categories. Many important cases – cases relating to guardianship, conditions of treatment (whether that is medical treatment, or institutional conditions generally), confidentiality, non-discrimination (a particular concern for countries ratifying protocol 12 to the ECHR) and so many other matters - will raise issues under both the ECHR and the CRPD. Once again, the key here is likely to be to ensure that States Party are not placed under conflicting obligations, while at the same time ensuring that the field is appropriately covered. This is likely to prove a complex process for both bodies. In some of these areas, the ECtHR has an established jurisprudence, and such jurisprudence can be difficult to change. In other areas (non-discrimination being perhaps the clearest example), the two bodies will each be developing jurisprudence from a relatively limited base, contemporaneously. While that provides the potential for coherence, it also has the potential for difficulties, as both bodies feel their way in new territory.

Thus far, the ECtHR appears to be proceeding with caution. Certainly, litigants before the Court now cite the CRPD, and the ECtHR fairly routinely cites the CRPD as part of the international law context of cases.[30] It has actually referred to the CRPD in its own analysis of ECHR law only twice. In both cases, the Court has referred to the CRPD as evidence of an international consensus that discrimination on the basis of disability is no longer acceptable, and that disability should therefore be included by implication in the open-ended list of prohibited grounds of discrimination under Article 14.[31] While this development is certainly welcome both in its own right and as an indication of overall harmonisation of international human rights law, it is consistent with the overall direction of ECHR jurisprudence, and did not require a significant change of course for the Court. It remains to be seen how the Court will deal with harder cases, where clashes with existing ECHR jurisprudence are unavoidable.

3 Herczegfalvy: The Original Decision

Mr Herczegfalvy was a Hungarian citizen resident in Austria, who was imprisoned periodically commencing in 1972, following conviction for a variety of assaults on his wife, public officials, and clients of his television repair business. Following numerous complaints by him about prison conditions, the Austrian authorities commissioned a psychiatric report about him, on the basis of which he was brought before a guardianship court (*Pflegschaftsgericht*) in 1977 and an 'advisor' (*Beistand* – hereinafter 'guardian'[32]) was appointed for him. While that court found Mr Herczegfalvy only partly incapacitated (*beschränkt entmündigt*), it would seem that this guardian exercised control over all personal and property-related decisions concerning him. It would appear that the guardian was kept informed, and agreed to, all the controversial acts imposed on Mr Herczegfalvy discussed below. Mr Herczegfalvy was eventually found not criminally responsible for these actions because of his mental disorder, and at the end of his sentence, his detention was continued based on his apparent danger to the public.

[30] See ECtHR, *Glor* v. *Suiss,* 6 November 2009; ECtHR, *Seal v. the United Kingdom*, 11 April 2011; ECtHR *Jasinskis v. Latvia*, 21 March 2011; ECtHR *Kiss v. Hungary*, 20 August 2010; ECtHR, *Kiyutin v. Russia*, 15 September 2011.
[31] See *Glor*, para. 53; *Kiyutin*, para. 57.
[32] 'Guardian' is selected because the individual in question does appear to have exercised real decision-making power over the applicant, an authority not implicit in the English term 'advisor'.

Mr Herczegfalvy's place of detention alternated between the general prison system and institutions for mentally ill offenders – matters considered at some length in the original judgment, but not pivotal to the present discussion. It was established, based on the reports of three psychiatrists, that he had suffered since at least 1975 with paranoia querulans, and he behaved in an aggressive fashion on an ongoing basis during his detention. He himself denied that he was mentally ill in this period, and continued to press his case before the courts, initially with a view to challenging his convictions, and then challenging his ongoing detention. Again, these legal manoeuvres occupy considerable discussion in the original decision, but will not be considered in detail here as they are relevant to his detention, not to his compulsory medical treatment. He was eventually released from detention in November 1984.

Throughout the period he spent in institutions, Mr Herczegfalvy continued to complain of the conditions of his detention. He suspected that these complaints were not forwarded to the relevant authorities. These suspicions proved well-founded: with the agreement of his guardian, his complaints had been retained by the institutions, and were returned to him at the time of his discharge. They filled six binders. He had also been denied access to television at various times during his detention. These matters were also litigated before the ECtHR.

The applicant had requested and been denied access to his files. While neither the Court judgment nor the Commission decision are entirely clear on the point, it would appear that this refers to files that he had created during his incarceration, not his clinical record or official administrative file. In response to the refusal to make these files available, and in protest to his continued detention generally, he commenced a hunger strike on 2 August 1979. On 10 September, because of his weakened condition, an order was made that he be given nutrition by force. As he was refusing all medical examination and treatment, he was given sedatives against his will (three doses of 30 mg each of Taractan IM). On 14 and 15 September, he was tied to a security bed, the net and straps of which he successfully cut through. On 17 September, he was given a different neuroleptic, Sordinol. He ceased the hunger strike on 27 September, after being allocated a single room and being given some of his files. The hunger strike recommenced however on 26 November. He was fed by tube commencing on 13 December 1979, a process which continued on a periodic basis until November 1982. His consent to this intubation was disputed.

On 15 January 1980, he was injected by force with 90mg of Taractan in order to bring about a state of somnolence, to make treatment with perfusions possible. Since he actively resisted this injection, an emergency team was required to overpower him. The Commission notes that the precise facts of this event are unclear, but he was transferred to the hospital's intensive care unit, where he was found to be suffering from pneumonia and nephritis. Upon his return to the closed psychiatric ward on 30 January 1980, he was handcuffed and a belt was placed around his ankles, apparently because of the danger of aggression and the death threats he was making. These restraints were not removed until 14 February 1980. It is not clear how frequently the position of the restraints was altered in this period.

The factual account and Court's approach to the case raise a number of concerns. The applicant was diagnosed with 'paranoia querulans'. This disorder is referred to briefly in ICD-10 in its residual category of delusional disorders, [33] but no proper definition is provided. The academic literature identifies it as the psychiatric disorder associated with persistent complaining and vexatious litigation,[34] and the potential for abuse of this diagnosis had been noted by the time

[33] This is essentially similar to the approach in ICD-9, in effect at the time Herczegfalvy was decided: see ICD-9, 297.8 'Other Specified Paranoid States'.

[34] See I. Freckelton, 'Querulent Paranoia and the Vexatious Complainant', *International Journal of Law and Psychiatry* 11 (1988), 127-143; P. Mullen and G, Lester, 'Vexatious Litigants and Unusually Persistent

Herczegfalvy was considered by the Court.[35] It is precisely the sort of diagnosis that ought to trigger the concern of the Court, for whatever its medical merits when properly applied, its potential to silence or marginalise legitimate complaints will be evident. Further, the subjects of those complaints may well be the medical staff responsible for making the diagnosis, a situation creating obvious conflicts of roles. It is therefore disappointing that the Commission and the Court did interrogate more carefully what precisely the diagnosis meant in the current case. It is acknowledged in paragraph 84 of the re-drafted judgment, where no decision is reached as to the accuracy of the diagnosis. This is in part because evidence is legitimately lacking in the factual history of the case, but it is also, again, strategic. In most cases, the existence of a mental disorder will not be seriously contested, and it seemed more helpful to proceed on that premise.

Was this in fact a disorder 'of a nature or degree warranting confinement'? Again, it is very difficult to tell from the factual account provided in the Commission decision and the Court's judgment. In paragraph 22 of the judgment, the Court summarises without criticism the decision of the Austrian Regional Court in February 1984 to order the continued detention of the applicant:

> Taking into account the opinions of the psychiatric expert and the director of the hospital, filed on 25 January 1984, it considered that there had been no fundamental change in Mr Herczegfalvy's mental state. He was still suffering from paranoia querulans, and if released would undoubtedly refuse to follow the necessary course of treatment; he would consequently be likely to bring numerous complaints or even carry out the threats he had made, in particular those against the prison staff.

It goes on in paragraph 23 of the judgment however to repeat uncritically the comments of the Regional Court in November of that year, ordering the applicant's release:

> The court found that the applicant's paranoia had admittedly worsened, but that it was primarily due to his detention (*Haftquerulanz*); the vexatious complaints and petitions (*Rechtsquerulanz*) did not constitute a danger within the meaning of Article 21 of the Criminal Code; since being detained the applicant had behaved with genuine aggressiveness on a few occasions only; although the possibility could not be excluded of his becoming aggressive in the event of frustration, his psychiatric history did not permit the conclusion that his abnormal personality would induce him to commit criminal offences; moreover, continued psychiatric treatment or treatment by drugs was not considered necessary by the expert, although it was recommended.

This raises questions about the initial and ongoing justifications for detention. The finding of the November court that the applicant had behaved with genuine aggressiveness only on a few occasions is startlingly inconsistent with the ongoing allegations of dangerousness and violence elsewhere in the case, undercutting the justification for the use of force and detention. Which characterisation is correct? Further, the applicant was a persistent complainer – a core symptom of his diagnosed disorder – but it is difficult to see why this constituted a justification for detention up to the end of 1984, and, according to the Court, not thereafter. And insofar as the applicant was dangerous or violent, was this in fact a consequence of his mental disorder? How is the change in judicial approach in the domestic courts between the two hearings to be understood? It does seem, at the very least, that this is yet another case where the criteria of detention lack the clarity required to ensure reasonably consistent decision-making.

Complainants and Petitioners: From Querulous Paranoia to Querulous Behavior', *Behavioral Science and the Law,* 26 (2006), 333-349.

[35] See, eg., O. Stalstrom, 'Querulous Paranoia: Diagnosis and dissent', *Australian and New Zealand Journal of Psychiatry* 14 (1980), 145.

It also raises questions about the ECtHR's consideration of Article 8 and of the control of the applicant's correspondence. Mr Herczegfalvy was periodically deprived of writing materials so that he could not file complaints, and such letters as he was able to write, unless addressed to his lawyer, his guardian or the Guardianship Court, were only delivered with the guardian's approval. Upon discharge, unsent letters returned to the applicant included those addressed to the police, the public prosecutor's office, and the courts.[36] The Court does find a violation of Article 8 on the basis that the statutory justification for the control of correspondence was insufficient, but the retention of letters directed to official offices of complaint is a matter particular concern, and it is unfortunate that the Court did not make that point with particular force. The issue concerns mechanisms of complaint, not the standards for involuntary medical treatment, so the issue is not dealt with in the re-drafting, but it serves as a reminder how problematic *Herczegfalvy* is as a case.

Facts about the enforced neuroleptic medication are similarly unclear. Was it intended to address an underlying psychiatric condition, or was it prescribed for its sedative properties only? At times in the judgment, it appears to be the former, but this interpretation is not entirely consistent with other statements of fact in the judgment. Thus for the hearing on 14 February 1984, the hospital director provided evidence, in the ECtHR's paraphrase, that 'the treatment carried out, based on medication, had only a sedative effect, the possibility could not be excluded that if he were released, he would again become aggressive and dangerous.'[37] If the medication was provided solely to sedate the applicant, should it be considered medical treatment or restraint? If it is for restraint, in what sense would it be 'medically necessary'? Certainly, restraint may in some cases be necessary, and in some cases may be necessary for considerable periods of time; but that is not an argument to consider it medical treatment. This issue will be of particular relevance in cases concerning homes for the aged, social care homes, and homes for people with learning disability – contexts where there are periodic complaints that medication is used for control rather than treatment - but it arises in *Herczegfalvy* as well.

In the redrafting, it is assumed that the treatment with neuroleptic medications was provided for medical reasons – that is, that it was directed to his underlying condition, rather than for his restraint.[38] This choice was made primarily for pragmatic purposes. Some clearly sedative medication was given to the applicant; that is dealt with as restraint. Treating the neuroleptics also as restraint seemed to add nothing to that analysis. Further, overwhelmingly, psychiatric medication is prescribed with the intent of curing the individual, or at least, significantly improving his or her condition, and *Herczegfalvy* has been taken to be a landmark case in the Court's approach to these issues. That question was thus pivotal to the redrafting project, and the factual interpretation was made accordingly, to provide an occasion for that analysis.

The Court's silence on the question of whether the applicant had an effective domestic remedy is similarly troubling. It does seem that there was jurisdiction for the Austrian Administrative Court (*Verwaltungsgerichtshof)* to determine the legality of the treatment received by Mr Herczegfalvy, and for the Constitutional Court (*Verfassungsgerichtshof)* to determine its constitutionality, but the Court notes that these mechanisms had never actually been used for this purpose.[39] The Court declines to make a finding on the applicant's claim for a consequent violation of Article 13, a refusal based on its finding that for the issues of control of correspondence and access to information (flowing from a denial of access to television), violations of articles 8 and 10 had already been found. Interestingly, the Court does not refer to the issues of enforced treatment,

[36] *Herczegfalvy* para. 37.
[37] *Herczegfalv,y* para. 33.
[38] See paragraph 84 of re-drafted judgment.
[39] *Herczegfalvy*, para. 55.

where Article 3 would be satisfied in cases of medical necessity, but where the Court 'must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist'.[40] If this is the standard chosen by the Court, it must surely be appropriate to insist that a domestic remedy be available to ensure that it is met in individual cases. It would seem that the Austrian courts were not used for this purpose at the time, and that raises an Article 13 issue. It is disappointing, and somewhat surprising given the Court's generally good record on matters of procedure, that this was not explored much more closely. In particular, it is hoped that the Court will focus both on the impartiality of such remedies, and on the practicalities of gaining access to them, including the provision of information about remedies and access to legal counsel, with legal aid available when necessary. Access to these remedies must similarly not lie within the control of a guardian or similar figure.[41]

As noted above, the bulk of the legal reasoning in the case concerns Article 5 issues. While some of the remarks made elsewhere in this paper and in the re-drafting will apply to those issues, they are not the matters for which the case is known, and they are not discussed in detail here. The case is instead known for its approach to psychiatric care and treatment as it relates to Article 3. Those issues form the core of the re-drafting, and it is to those issues that this paper now turns.

4 Herczegfalvy and Care and Treatment in Psychiatric Institutions

Regarding the care and treatment of the applicant, the Commission had found a violation of Article 3, based on the degree of force used over an excessively prolonged period. The government in response claimed that the measures had been urgent with a view to the deterioration in Mr Herczegfalvy's physical and mental health, and because of his 'resistance to all treatment, his extreme aggressiveness and the threats and acts of violence on his part against the hospital staff'.[42] The government also noted that the measures in question had been agreed by Mr Herczegfalvy's guardian, and were for the least time reasonably possible.

The Court's reasons are contained in paragraph 82 of the case:

> 82. The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible, such patients nevertheless remain under the protection of Article 3 (art. 3), whose requirements permit of no derogation.
>
> The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.

On all relevant points, the Court finds there is insufficient evidence to disprove the government's position. Thus notwithstanding the Commission's expression of disappointment at the poor calibre of evidence concerning the events in January 1980 that resulted in the applicant's handcuffing, the Court was not prepared to look behind the government's submission that 'according to the

[40] *Herczegfalvy*¸ para. 82.
[41] See para 90 of re-drafted judgment.
[42] *Herczegfalvy*, para. 81.

psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue'.[43] As a result, no violation of Article 3 was found. Similarly, when it considers Article 8 on these points, it finds a lack of specific evidence sufficient to displace the government's view that the hospital authorities were justified in regarding the applicant's psychiatric illness as rendering him 'entirely incapable of taking decisions for himself'.[44] Both these findings are problematic. Regarding the physical restraints, the CPT took a different view in its standards for detention in psychiatric institutions, written only a few years after the *Herczegfalvy* decision:

> The CPT has on occasion encountered psychiatric patients to whom instruments of physical restraint have been applied for a period of days; the Committee must emphasise that such a state of affairs cannot have any therapeutic justification and amounts, in its view, to ill-treatment.[45]

Regarding the capacity, it should be noted that the Austrian courts made a finding only of partial capacity of the applicant.[46] It is not clear from the ECtHR judgment or Commission decision what specific decisions the domestic court considered that he could not make, and whether that situation had changed between the initial decision in November 1977 and the events of the case. It is further not clear whether the medical staff were relying on the court decision or on their own evaluation of the applicant's capacity, and if the latter, what the legal parameters and status of that evaluation was.[47]

While this is not the place to launch into a detailed analysis of the evidential rules and practices of the Court, it is appropriate to note the considerable inequality of arms between persons detained in psychiatric facilities and the governments and staff who administer those facilities. In other contexts, such as where an injury occurs in a closed institution, the Court places an onus on the state to provide a credible explanation of the injury. [48] It is reasonable to hope that the Court will extend this onus to require explanations whenever force is used in institutions, and in particular whenever violations of Article 3 are at issue. This may, perhaps, be implicit in the Court's requirement that 'the medical necessity has been convincingly shown to exist', but a clearer statement of the evidential principle would be welcome. For purposes of the re-drafting exercise, a different view of medical necessity of handcuffing has been taken, consistent with the CPT standards, and the issue of the applicant's ability specifically to consent to medical treatment has been left unresolved (paragraphs 94 to 98 of the re-written judgment regarding handcuffing, and paragraph 90 regarding capacity). This last is in part a stylistic ruse to allow for discussion of compulsory treatment both in situations when the individual has capacity, and when he or she has not; but it also reflects the facts of *Herczegfalvy* as reported: we really do not know whether or not he had capacity to make the relevant decisions.

The overall approach of the Court is to state that when an action is 'medically necessary', it will not be a violation of Article 3.[49] The first difficulty with this standard is that it is not at all clear

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[43] *Herczegfalvy*, para. 83.
[44] *Herczegfalvy*, para. 86.
[45] Extract from the 8th General Report [CPT/Inf (98) 12].
[46] *Herczegfalvy*, para. 10.
[47] These ambiguities are reflected at paragraphs 89-90 of the re-drafted judgment.
[48] See, for example, ECtHR, *Selmouni v. France*, 28 July 1999, (2000) 29 EHRR 403, para. 87;ECtHR, *Aksoy v. Turkey*, 26 November 1996, (1996) 23 EHRR 553, para. 61; ECtHR *Ribitsch v. Austria*, 21 November 1995, (A/336) (1996) 21 EHRR 573, para. 34.
[49] For a detailed discussion of this phrase in an English context, see P Bartlett, '"The Necessity must be Convincingly Shown to Exist": Standards for Compulsory Treatment for Mental Disorder under the Mental Health Act 1983', *Medical Law Review*, 19 (2011) 514-547, available on open access at http://medlaw.oxfordjournals.org/content/19/4/514.full.pdf+html (accessed 29 November 2011).

what 'medically necessary' means. It must be a higher standard than merely 'medically appropriate': the fact that an appropriate treatment is available should not mean that a State should be able to force people to have it. 'Medical necessity' as intended by the Court presumably does not mean that without such treatment the patient will suffer death or serious physical injury, since least as regards the neuroleptic medication, it is not obvious that this would have been the result in *Herczegfalvy* itself. The degree to which treatment can be enforced in order to safeguard others in society is likely to prove a controversial point, and to raise serious substantive arguments under the ECHR. Is the degree of likelihood of success relevant – that is, even to prevent death, can it be said that a highly intrusive and painful treatment with a low probability of success is 'medically necessary'? These and many other questions are left unanswered by the standard articulated.

If the standard is going to be meaningful, therefore, it must be articulated in a much clearer fashion. Certainly, this is appropriately an area where a margin of appreciation should apply and domestic legislation should take the lead, but the issue of substantive clarity discussed above remains relevant: domestic legislation must establish real criteria, and those criteria must be defensible in human rights terms. The re-drafting indicates some possible ways of approaching the issue (see paragraph 89 of re-written judgment). While the treating physician may be best placed to make an initial evaluation of the situation, it needs to be noted that he or she is too close to the situation for the process to end with him or her. Further, the scope of the State's right to impose treatment raises a variety of political, legal and social issues as well as medical ones. This is not a purely medical matter, and the process must allow for an independent review of the decision.

So when, if at all, should compulsory treatment be permitted? The re-drafting makes the case that mere detention in a psychiatric institution is not sufficient, nor, a fortiori, is the mere presence of a mental disorder. The re-drafting makes the case that the actual capacity of the individual to make the decision will be relevant but not necessarily determinative in all cases (paragraphs 86 to 90 of re-written judgment).

It is difficult to imagine a matter more directly related to the right to physical and personal integrity and autonomy than the right to control the chemicals that are introduced to one's body. This is an important point whatever the chemicals are, and is this case even if the medicines were unproblematic. An absence of adverse effects may well be relevant to whether an individual wishes to consent to medication, but it is not an argument for the removal of that consent. Many medications, most psychiatric medications included, are not unproblematic. Taractan, the neuroleptic prescribed for Herczegfalvy, is the trade name of chlorprothixene. Its adverse effects include highly sedative properties, dry mouth, massive hypotension and tachycardia, hyperhidrosis, substantial weight gain and extra-pyramidal effects such as Parkinsonianism, dystonia (abnormal face and body movements), restlessness, and tardive dyskinesia (rhythmic, involuntary movements of tongue, face, and jaw). These extra-pyramidal effects can be permanent. It should be emphasized that psychiatric medication can also have very positive effects; but benefits may well come at a cost. Psychiatric inpatients may also have long experience with prescribed drugs, and have firm and defensible views as to what, if anything, they wish to take for their condition based on what seems to them to provide the best balance of improvements and adverse effects.

The re-drafting acknowledges the potential impact of the CRPD in matters of consent, and in particular the strong wording of the CRPD defending the right of people with disabilities to consent to treatment (paragraph 89 of re-drafted judgment). It does seem that the CRPD will take a very narrow view of incapacity, and deprivation of the right to consent to treatment on this basis will need to be very carefully circumscribed by national governments, if indeed the CRPD allows it at all.

All of this is overlaid by a policy of non-discrimination (paragraph 86 of re-written judgment). While the Court has not yet interpreted Article 14 in the context of mental disability, it has done so in the context of physical disability in sufficiently expansive terms to suggest that discrimination on the basis of mental disability will also be within the scope of Article 14,[50] and, by extension, Protocol 12. The CRPD similarly places great evidence on non-discriminatory approaches in these areas. It is therefore likely to be the case that it will allow compulsory treatment of mental disorders if compulsion would also be allowed for physical disorders of comparable seriousness, and in cases of people without mental or other disabilities.

In essence, the argument regarding Article 3 is that meaningful substantive standards consistent with international law, as well as appropriate procedural standards, must be developed. What appears to be an almost off-hand reference to 'medical necessity' in the original *Herczegfalvy* case needs to be expanded to provide a real substantive standard; and the effects of compulsory and unwanted treatment on capable and non-capable people must be re-articulated within the framework of Article 3.

That in turn raises issues relating to Article 8. If, as is argued, non-consensual treatment is sufficient to bring Article 3 into consideration, it must also be sufficient to engage Article 8(1); and this is consistent with the existing jurisprudence on the point. To satisfy Article 8(2), however, actions must be 'in accordance with law', and as discussed elsewhere in this article, that requires a certain degree of specificity. This approach found favour with the Court concerning the withholding of Mr Herczegfalvy's correspondence under Article 8 and the withholding of information from him (caused by removal of his access to television) under Article 10, and the Court provides an pointed dismissal of the Government's attempt to rely on the Hospitals Law and the Civil Code:

> 91. These very vaguely worded provisions do not specify the scope or conditions of exercise of the discretionary power which was at the origin of the measures complained of. But such specifications appear all the more necessary in the field of detention in psychiatric institutions in that the persons concerned are frequently at the mercy of the medical authorities, so that their correspondence is their only contact with the outside world.

One must view these comments with enthusiasm; but it is inescapable to note that the aspects of those same laws that concern involuntary treatment are no more clearly defined; and yet the Court makes no comment on them. Is it really the Court's position that involuntary psychiatric treatment warrants less protection than access to television?[51]

5 Conclusion

The ECtHR did not consider matters relating to mental disability for almost thirty years following its establishment. A trickle has now become, if not a flood, at least a determined stream, and there is much in the Court's record for it to be proud of. At the same time, people with mental disabilities remain the subject of stigma throughout the Council of Europe, and the human rights issues relating to them remain real and pressing. The Court has been instrumental in bringing about procedural standards throughout the Council of Europe, but in the end, process is not enough. Substantial standards must be required, that ensure improved services, dignity and respect for the affected populations.

[50] See *Glor* v. *Switzerland,* 6 November 2009, eg. at para. 53.
[51] These issues are considered at paragraphs 107-108 of the re-drafted judgment.

Rewriting *Herczegfalvy* v. *Austria*.

[additions to original judgment are in blue; deletions are struck out]

IV. ALLEGED VIOLATION OF ARTICLE 3 (art. 3)

79. Mr Herczegfalvy also complained of his medical treatment. In that he had been forcibly administered food and neuroleptics, isolated and attached with handcuffs to a security bed during the weeks following the incident of 15 January 1980 (see paragraphs 24-28 above), he had been subjected to brutal treatment incompatible with Article 3 (art. 3), according to which:

> "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

80. The Commission considered that the manner in which the treatment was administered had not complied with the requirements of Article 3 (art. 3): the various measures complained of had been violent and excessively prolonged, and taken together had amounted to inhuman and degrading treatment, and even contributed to the worsening of the patient's condition.

81. In the Government's opinion, on the other hand, the measures were essentially the consequence of the applicant's behaviour, as he had refused medical treatment which was urgent in view of the deterioration in his physical and mental health.

Thus when Mr Herczegfalvy returned to the hospital on 10 September 1979 it proved to be necessary to feed him artificially, in view of his extremely weak state caused by his refusal to take any food (see paragraphs 24-25 above). Later on, it was partly at his own request that he was fed through a tube, while continuing - at least ostensibly - with his hunger strike.

Similarly, it was only his resistance to all treatment, his extreme aggressiveness and the threats and acts of violence on his part against the hospital staff which explained why the staff had used coercive measures including the intramuscular injection of sedatives and the use of handcuffs and the security bed. These measures had been agreed to by Mr Herczegfalvy's curator, their sole aim had always been therapeutic, and they had been terminated as soon as the state of the patient permitted this.

Finally, the Government claimed that the isolation complained of had in fact consisted of being placed in an individual cell, in accordance with Mr Herczegfalvy's wishes. He had had contact with doctors and nurses, and had been able to receive visits and even walk in the garden.

82. The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. ~~While it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible~~ While the Court acknowledges the complexities of administering psychiatric hospitals and similar institutions for people with mental disorders, such patients nevertheless remain under the protection of Article 3 (art. 3), whose requirements permit of no derogation.

~~The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.~~

83. The Court considers that two broad issues arise. One relates to the use of force in the provision of food and medicine to Mr Herczegfalvy, and the other to the implementation of restraint and isolation upon Mr Herczegfalvy during his detention.

Compulsory Medical Treatment

84. The applicant was treated without his consent at various times, with sedatives and, on an ongoing basis and certainly for several weeks following 15 January 1980, with neuroleptic medication. In addition, he was forcibly fed during his hunger strike, commencing when his malnutrition became pronounced. The sedation was not directed to treatment or cure of the underlying condition of the applicant, but rather to the control of the patient both to regain order on the ward and to subdue him so that treatment directed to his condition could take place. It will be considered as part of the applicant's restraint, rather than medical treatment. The treatment with neuroleptic medication and the force-feeding will be considered in turn.

Compulsory treatment must perforce be directed to a true medical disorder with which the individual is affected. Compulsory treatment of an individual who is not reasonably believed to be suffering from such a disorder will almost inevitably constitute a violation of Article 3. It is to be expected that diagnoses will be made in good faith, consistent with a reasonable standard of professional competence, and consistent with a recognised medical diagnostic manual such as the United Nations International Classification of Diseases (ICD-10). While they may turn out to be incorrect, they must be objectively and demonstrably credible at the time they were made.

This case creates some difficulties in this regard. The applicant was diagnosed with paranoia querulans. While this disorder is acknowledged in ICD-10 under 'Other paranoid states', no definition is provided. It would appear to be characterised by consistent complaining and vexatious litigation, precisely the behaviour that triggered the applicant's transfer from prison to hospital. The potential for abuse of this diagnosis by pathologising troublesome individuals has been acknowledged in the academic medical literature, and the enforced medication of an individual based on his or her merely being 'troublesome' rather than legitimately suffering from a mental disorder would certainly raise the prospect of a violation of Article 3. Because of the Court's findings elsewhere in this judgment, it is not necessary to reach a firm conclusion on the accuracy of the diagnosis in this case, but it would reiterate that convincing objective evidence of a true mental disorder must be shown to exist when compulsory treatment is at issue.

Assuming the appropriateness of the diagnosis, the Court accepts that the treatments with neuroleptic medication were given under medical supervision and directed to the treatment of the mental disorder from which the applicant was suffering. The Court does not question their medical appropriateness. The established principles of medicine are decisive on this point, and had the applicant given free and informed consent to the treatments, no issue under Article 3 would arise. The potential issue under Article 3 is whether the compulsory or non-consensual nature of the treatment alters that position.

85. The case of *Kudła v. Poland* (Application No. 30210/96, judgment 26 October 2000) provides guidance as to the scope of inhuman or degrading treatment:

> The Court has considered treatment to be "inhuman" because, *inter alia*, it was premeditated, was applied for hours at a stretch and caused either actual bodily injury or intense physical or mental suffering. It has deemed treatment to be "degrading" because it was such as to arouse in the victims feelings of fear, anguish and inferiority capable of humiliating and debasing them. On the other hand, the Court has consistently stressed that the suffering and humiliation involved must in any event go beyond that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment. [para 92]

While any intent to degrade or treat in an inhumane fashion is relevant to a finding of a violation under Article 3, it is not a requirement: *Peers v. Greece* (Application No. 28524/95, judgment 19 April 2001, para 74; *Price v. UK*, Application No. 33394/96, judgment 10 July 2001, para 30).

86. The Court notes that behaviour must reach a minimal level of severity to fall within the scope of Article 3. It also notes that the control of one's bodily integrity, and the right to consent to or to refuse medical treatment, constitutes a fundamental aspect of bodily autonomy. The over-ruling of a refusal and the forced imposition of medical treatment, particularly when that treatment involves surgical or similarly intrusive physical intervention, or the use of strong medications, is bound to give rise to the feelings of fear, anguish and inferiority referred to in the *Kudła* decision. Treatment provided in such circumstances falls within the scope of Article 3. Treatment with neuroleptic medication is certainly sufficiently intrusive to meet this threshold, and any treatment with such medication without the consent of the patient is within the scope of Article 3. That is the situation in the current case, and the Court therefore holds that the enforced treatment with neuroleptics falls within the scope of Article 3.

This therefore triggers Article 14 as an aid to interpretation of Article 3. Enforced treatment should not be discriminatory in its effect. This applies not merely on the basis of the articulated grounds contained in Article 14, but also on the basis of disability: *Glor v. Switzerland* application no 13444/04, judgment of 6 November 2009. While that case refers specifically to physical disability, the same principles must apply to mental disability. The fact that an individual has a mental disability, therefore, will not of itself justify a lower standard for enforced treatment, and criteria which impact disproportionately on people with mental disability must be objectively justifiable.

While the capacity of an individual to make the relevant treatment decision will be relevant to whether a breach of Article 3 occurs, the fact that an individual lacks such capacity does not place the factual situation outside the scope of Article 3. The pivotal question, based on the language in *Kudła*, is whether the actions complained of are such as to cause the individual feelings of fear, anguish and inferiority. Those lacking mental capacity are not immune from these feelings. They are also among the most vulnerable in institutions, and their situation warrants the particular attention of the Court.

The Court must therefore consider whether there is a violation of Article 3 in this case.

87. The mere fact that an individual is detained in a psychiatric facility will not be sufficient to justify compulsory psychiatric treatment. The Court has elsewhere held that the detention of persons in psychiatric facilities under Article 5(1)(e) may be justified not merely for therapeutic reasons, but also for reasons relating to the danger posed by the person detained as a result of his or her psychiatric condition: see, eg., *Hutchinson Reid v. the United Kingdom*, Application No. 50272/99, judgment 20 May 2003. The detention removes the immediate social danger posed by the individual; it does not follow that the state acquires a consequent right to treat the individual without his or her consent. Even if the individual is detained for sake of his or her health, it does not

follow that he or she may be compulsorily treated. It is a non sequitur to say that because treatment is medically appropriate or even necessary, it may be given without consent. This is as true in a psychiatric context as it is for physical disorders.

This is consistent with the approach of the Committee for the Prevention of Torture, whose standards state:

> Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances. [CPT Standards, CPT/Inf/E (2002) 1, Rev 2004, p. 57, para 41.]

88. The CPT standard falls short of stating that involuntary treatment may never be given to detained patients without consent. Other European and international instruments are similarly not absolutely prohibitive. The Recommendation of the Committee of Ministers to member States concerning the protection of the human rights and dignity of persons with mental disorder, Rec(2004)10, similarly sets out different criteria for involuntary treatment and involuntary detention. The substantive recommendations concerning involuntary treatment are as follows:

> **Article 18 – Criteria for involuntary treatment**
> A person may be subject to involuntary treatment only if all the following conditions are met:
> i. the person has a mental disorder;
> ii. the person's condition represents a significant risk of serious harm to his or her health or to other persons;
> iii. no less intrusive means of providing appropriate care are available;
> iv. the opinion of the person concerned has been taken into consideration.
>
> **Article 19 – Principles concerning involuntary treatment**
> 1. Involuntary treatment should:
> i. address specific clinical signs and symptoms;
> ii. be proportionate to the person's state of health;
> iii. form part of a written treatment plan;
> iv. be documented;
> v. where appropriate, aim to enable the use of treatment acceptable to the person as soon as possible.
> 2. In addition to the requirements of Article 12.1 above, the treatment plan should:
> i. whenever possible be prepared in consultation with the person concerned and the person's personal advocate or representative, if any;
> ii. be reviewed at appropriate intervals and, if necessary, revised, whenever possible in consultation with the person concerned and his or her personal advocate or representative, if any.
> 3. Member states should ensure that involuntary treatment only takes place in an appropriate environment.

89. States enjoy a margin of appreciation in their implementation of the Convention, and within the framework of the Convention and other international law. Nonetheless, a few points may provide guidance as to the Court's approach in this area.

The decisions of a competent individual warrant particular respect, and may be overridden only for the most compelling reasons, if at all. The United Nations Convention on the Rights of Persons with Disabilities includes an express provision that treatment is to be provided on the basis of 'free and informed consent' (UN A/61/611, Article 25(d)). This is coupled with an article that maximises the number of people who have legal capacity (Article 12), and thus have the legal right to exercise that consent. Further, the logic of the Court expressed above notes that the degradation implied in enforced treatment flows from the violation of selfhood that is inherent in the removal of the right of an individual to control chemical interventions to his or her body. That violation is most pronounced in the case of an individual with capacity to make the relevant decision.

As the potential violation of Article 3 flows from the removal of an individual's control over his or her self, the availability of procedural challenges prior to such interventions will be relevant to the way in which the affected person will experience the intervention. Article 3 violations are therefore less likely to occur when the right of the affected person to challenge the decision to enforce treatment is available. Appropriate legal representation must be provided as required for such challenges, with particular attention accorded to the situation of persons lacking or of marginal capacity. The Court notes that the Recommendation of the Committee of Ministers includes provisions relating to such reviews and appeals (Article 25).

The fact that treatment is in the medical best interests of an individual will not be sufficient to justify its forced administration. The likelihood of an Article 3 violation will depend on a range of variables. Where the individual has capacity, as noted above, his or her refusal of treatment should be overridden only in extreme cases, as for example in cases of immediate necessity of treatment to preserve life, if at all. Additional possible factors include, but are not restricted to, the certainty of the medical practitioners as to the diagnosis, prognosis and appropriate treatment for the patient, the seriousness of the disorder to be treated, the probability of success of the course of treatment, the potential adverse effects of the treatment, the nature and availability of alternative treatments and of failure to treat the patient, the positive and negative experiences of the patient with similar treatments in the past, and the capacity of the patient to consent to the intervention. Where the individual lacks capacity, in addition to the factors noted above, the views of the individual when competent and the values that the individual would have brought to the decision will always be highly relevant. The degree and nature of the objection of individuals lacking capacity will also be relevant. The Court reiterates that for capable and incapable patients alike, different standards must not apply between psychiatric and other treatments of comparable invasiveness and severity, nor between psychiatric and other patients, regarding the criteria to be used in enforcing treatment: the criteria must be applicable without discrimination.

90. In applying these principles, the facts of the current case are insufficient in a number of pivotal aspects. The facts regarding the incident on 15 January 1980 remain unclear, notwithstanding the Commission's request for further particulars. Further, the Court notes that capacity is a decision-specific concept that may vary considerably over time: people may have capacity at some times and not at others, and have capacity for some decisions and not others. While it is clear that the applicant was subject to a guardianship order, it is not clear from the facts whether he was in fact competent to make relevant treatment decisions on 15 January 1980, and if not, whether or at what point he became competent to make those decisions. Information was not provided to the Court about the potential adverse effects of the medications (although the Court notes that the adverse effects of many neuroleptic medications can be serious), nor likelihood and

degree of success of the proposed intervention. The Court was not told the procedures by which the proposed course of action was adopted, and it is therefore unaware of the degree to which the views of the applicant were taken into account. While the facts are not entirely clear, it seems that there were no established criteria for these decisions, and that considerable discretion was left to doctors without meaningful guidance as to how that discretion was to be exercised. While considerable latitude must be accorded to the treating authorities in situations of emergency, as may have been the case on 15 January 1980, it is not clear that appropriate procedures were in place to be followed in the weeks following that time, during which the compulsory treatment continued.

The Court notes the limited mechanisms for the applicant to require review of these decisions. The acts of the hospital, like any administrative act, could in theory have been challenged as to its lawfulness before the Administrative Court (*Verwaltungsgerichtshof)* and as to its constitutionality before the Constitutional Court (*Verfassungsgerichtshof)*, however as noted in paragraph 55, there are no examples of such applications against psychiatric hospitals relating to situations analogous to those in the current case. The Court therefore questions the practicality of this mechanism. These doubts are buttressed by the fact that the hospital was already failing to forward complaints by the applicant to the courts. The Court therefore holds that meaningful challenge to the decisions of the hospital were denied to the applicant.

91. On this basis, the Court holds that the enforced treatment with neuroleptic medication over the objections of the applicant constituted inhuman or degrading treatment, and the Court therefore finds a violation of Article 3.

92. The forced feeding of the applicant should be analysed in broadly similar terms. The physical violation of bodily integrity that this intervention involved, over the active objection of the applicant, was sufficient to bring the actions within the scope of Article 3 (see *Nevmerzhitsky v. the Ukraine*, Application No. 54825/00, judgment 12 October 2005).

As to whether there was a violation of that Article, the Court notes the ambiguity of European and international human rights instruments as to whether a hunger strike should be permitted to continue. Thus paragraph 63 of Recommendation No. R (98) 7 of the Committee of Ministers to Member States concerning the ethical and organisational aspects of health care in prison provides:

> 63. If, in the opinion of the doctor, the hunger striker's condition is becoming significantly worse, it is essential that the doctor report this fact to the appropriate authority and take action in accordance with national legislation (including professional standards)."

The relevant extracts from Chapter III of the CPT Standards of "Health care services in prisons" [CPT/Inf/E (2002) 1, Rev. 2004] and extracts from the 3rd General Report [CPT/Inf (93) 12] read as follows:

> 47. Every patient capable of discernment is free to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances which are applicable to the population as a whole.
>
> A classically difficult situation arises when the patient's decision conflicts with the general duty of care incumbent on the doctor. This might happen when the patient is influenced by personal beliefs (eg. refusal of a blood transfusion) or when he is intent on using his body, or

> even mutilating himself, in order to press his demands, protest against an authority or demonstrate his support for a cause.
>
> In the event of a hunger strike, public authorities or professional organisations in some countries will require the doctor to intervene to prevent death as soon as the patient's consciousness becomes seriously impaired. In other countries, the rule is to leave clinical decisions to the doctor in charge, after he has sought advice and weighed up all the relevant facts.

The *Nevmerzhitsky* case itself identifies the conflict between the potential Article 3 violation and the duty on contracting States to protect the right to life:

> When, however, as in the present case, a detained person maintains a hunger strike this may inevitably lead to a conflict between an individual's right to physical integrity and the High Contracting Party's positive obligation under Article 2 of the Convention – a conflict which is not solved by the Convention itself" (see *X v. Germany* (1984) 7 EHRR 152). (para 93).

A violation of Article 3 was found in *Nevmerzhitsky* on the basis that even if medically necessary, the treatment was provided in a fashion that violated the applicant's Article 3 rights, and that procedural safeguards followed. Similar comments apply in the present case, and the Court therefore finds a violation of Article 3.

93. This does not necessarily entail that enforced feeding will constitute a violation of Article 3 in all subsequent case. The protection of life is the most compelling justification for enforced treatment, and the Court notes that domestic law can be phrased to ensure that such protections apply equally to people with mental disabilities and those without such disabilities. The Court would not wish to pre-judge future cases in this regard.

Restraint and Isolation

94. The applicant was subject to restraint on numerous occasions during his detention. On a number of occasions, he was subject to physical restraint. The most significant occurrence of such restraint occurred in a continuous period from 30 January to 14 February 1980, when the applicant was handcuffed to a security bed and had a belt placed around his ankles. He was also subject on various occasions to chemical restraint, including the forcible injection of 90mg of Taractan on 15 January 1980, to induce a state of somnolence so that he could be given other psychiatric treatment. It would seem that the applicant was further subject to segregation from other patients at various times, although the duration and intensity of this isolation was a matter of dispute between the parties.

95. The Court acknowledges that restraint and seclusion will on occasion be necessary in institutions, including psychiatric institutions. Such measures are justified when reasonably necessary to protect the health and safety of the person detained, or of other persons. Such measures must not be used as a form of punishment, and must continue only for the shortest time reasonably possible. They must also be of the least severity possible: *Ribitsch v. Austria*, Application No. 18896/91, judgment 14 November 1995, para 38.

96. As noted above, the facts regarding the incident on 15 January 1980 remain unclear. It does seem that the applicant was that day in poor physical health, but nonetheless became extremely agitated and fell into a rage. An emergency squad was called in response. Thereafter, the applicant

collapsed, and developed pneumonia and nephritis, which required urgent medical treatment elsewhere in the hospital. It would appear that all this restraint occurred under proper medical supervision.

97. The Commission concluded that the initial actions of the hospital were justified, but not the subsequent actions:

> 247. The overcoming of the physical resistance of a mental health patient lacking insight concerning the necessity of a particular treatment can, in certain circumstances, be regarded as necessary, especially if the treatment in question appears imperative. The Commission considers that the condition was at least initially met in the applicant's case. It is nevertheless doubtful whether in view of the applicant's reaction on 15 January 1980 it was really necessary to insist on the immediate administration of his compulsory treatment and apply massive force to this end, including overwhelming him by an emergency squad. The Commission notes in this context that this context that the use of force seems to have contributed to the applicant's state of agitation and his complete physical breakdown. It does not appear that the medical authorities could foresee this development when the treatment was started. They should, however, have reconsidered the appropriateness of the measures taken to overcome the applicant's physical resistance once their effect on his state of health became apparent.

98. The Court would express its reservations regarding the first sentence of the Commission's view, at least in the unnuanced way in which it is phrased. As noted in the previous section, the 'overcoming' of an individual who is objecting to treatment is a complex decision, containing a variety of factors. The Court does share the view in the remainder of the paragraph. It further notes the following comment from the CPT Standards concerning involuntary placement in psychiatric establishments (Extract from the 8th General Report [CPT/Inf (98) 12]):

> 48. Resort to instruments of physical restraint (straps, strait-jackets, etc.) shall only very rarely be justified and must always be either expressly ordered by a doctor or immediately brought to the attention of a doctor with a view to seeking his approval. If, exceptionally, recourse is had to instruments of physical restraint, they should be removed at the earliest opportunity; they should never be applied, or their application prolonged, as a punishment.
>
> The CPT has on occasion encountered psychiatric patients to whom instruments of physical restraint have been applied for a period of days; the Committee must emphasise that such a state of affairs cannot have any therapeutic justification and amounts, in its view, to ill-treatment.

In this case, the applicant was held in physical restraints – handcuffs and ankle belts – for a period of more than two weeks. As the Commission notes, the effect on him was traumatic, inducing a complete physical breakdown. In the view of the Court, this constituted a violation of Article 3.

99. Mr Herczegfalvy was also restrained with sedative medication commencing in January 1980. The most severe treatment of this sort commenced on 15 January 1980, but it is not clear from the facts how long sedation continued. It is also not clear the degree to which the neuroleptic medication given to the applicant on an ongoing basis had sedative (and therefore restraining) effects.

100. The Court acknowledges that some people may require sedation for significant periods, and that some medication provided for therapeutic reasons over a considerable time may have sedative

effects. The Court acknowledges that the use of medications for these purposes may remove the need for physical restraints, and may (depending on the physical restraint and the medications in question) be less severe than physical restraints. The same principles nonetheless apply to medications with sedative effects as apply to other restraints: they must not be used as a form of punishment, must continue only for the shortest time reasonably possible, and must be of the least severity possible. Medical professionals are thus required to re-visit medicinal restraint, as they would physical restraint, on a periodic basis to ensure that it remains justified.

101. The Court has already expressed its reservations about the calibre of the evidence in this case. Nonetheless, it does note that the applicant in this case had a history of violence that continued through most of his psychiatric detention. While the Court would in the future expect clearer evidence relating to the necessity of specific uses of chemical restraint, on this occasion it is minded to find that the use of sedative medication was justified.

102. The Court notes that the jurisdiction of the Austrian Administrative Court (*Verwaltungsgerischtshof*) and Constitutional Court (*Verfassungsgerichtshof*), while apparently available in principle to challenge the legality and constitutionality of enforced psychiatric treatment have never in fact been used for this purpose. The Court must therefore question whether these are in fact real avenues of redress for people subject to involuntary psychiatric treatment, and question whether the requirements of Articles 6 and 13 are met. As the issue was not pleaded before us in these terms, no finding is made on this point, other than to note the obligation of states to ensure mechanisms of redress for persons whose rights under this Convention are at issue.

~~83. In this case it is above all the length of time during which the handcuffs and security bed were used (see paragraphs 27-28 above) which appears worrying. However, the evidence before the Court is not sufficient to disprove the Government's argument that, according to the psychiatric principles generally accepted at the time, medical necessity justified the treatment in issue. Moreover, certain of the applicant's allegations are not supported by the evidence. This is the case in particular with those relating to what happened on 15 January 1980 (see paragraph 27 above) and the extent of the isolation.~~

~~84. No violation of Article 3 (art. 3) has thus been shown.~~

V. ALLEGED VIOLATION OF ARTICLE 8 (art. 8)

103. [85.] Mr Herczegfalvy further alleged that by administering food to him by force, imposing on him the treatment complained of and refusing to send on his correspondence, the hospital authorities had also violated Article 8 (art. 8), which reads as follows:

> "1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

~~86. The first two complaints relate to facts already complained of from the point of view of Article 3 (art. 3). Reference should therefore first be made to paragraph 83 above. In addition, the Court attaches decisive weight here to the lack of specific information capable of disproving the Government's opinion that the hospital authorities were entitled to regard the applicant's psychiatric illness as rendering him entirely incapable of taking decisions for himself. Consequently, no violation of Article 8 (art. 8) has been shown in this respect.~~

104. The substance of the first two complaints has already been considered from the point of view of Article 3. Article 8 however raises some technical points of relevance to these matters.

105. A compulsory medical intervention, even if slight, constitutes an interference with Article 8(1): *Y.F. v. Turkey* Application No. 24209/94, judgment 22 July 2003. Such an interference will only be permitted if justified under Article 8(2). It will be clear from the previous discussion that if non-consensual treatment is to be permitted under Article 3, it will only be because it has considerable and demonstrable therapeutic benefits (for the neuroleptic medication and the forced feeding), or is warranted as necessary for the protection of the patient or others (for the sedatives used for restraint). These would appear to be justified under Article 8(2) with reference to protection of health (for the medications) and for the prevention of disorder or crime, the protection of health, and for the protection of the rights and freedoms of others (for the restraint).

106. [88.] Article 8(2) also requires, however, that any reliance on Article 8(2) be 'in accordance with the law'. The Court recalls that the expression "in accordance with the law" requires firstly that the impugned measure should have some basis in national law; it also refers to the quality of the law in question, requiring that it should be accessible to the person concerned, who must moreover be able to foresee its consequences for him, and compatible with the rule of law (see, inter alia, the Kruslin and Huvig v. France judgments of 24 April 1990, Series A no. 176-A, p. 20, paras. 26-27, and no. 176-B, p. 52, paras. 25-26).[52] While the usual phrasing of this requirement is that the law's consequences be foreseeable to the person whose rights are at risk, the Court would note that it is equally important that the law be sufficiently precise and comprehensible that those charged with its administration will be clear what is expected of them, and so that there will be consistency of decision-making between these individuals. The Court notes that such clarity is particularly important in psychiatric and similar contexts, where initial decisions may well be taken by non-lawyers and where the people affected will be particularly vulnerable, and consequently not necessarily be in a position (or consider themselves to be in a position) where they can press for their rights or challenge decisions made about them. Without such clarity, rights become a lottery.

107. If non-consensual treatment is to be permitted, therefore, it must be given a firm and clear basis in domestic law. A mere repetition of the criteria identified in the discussion of Article 3, above, without further clarification will be insufficient. The margin of appreciation accorded to States Party to the Convention imports a corresponding duty onto the State to establish clear criteria that meet both the needs of the State and the terms of the Convention.

108. In this case, the Hospitals Law (*Krankenanstaltengesetz*) required patient consent only for 'special curative treatments including surgical operations'. The applicant had been found incapable of managing his affairs in 1975, and the Incapacitation Regulations (*Entmündigungsordnung*) coupled with relevant articles of the Civil Code (*Allgemeines Bürgerliches Gesetzbuch*) and the law on the appointment of curators of handicapped persons (*Sachwaltergesetz*) gave his curator an unfettered discretion to consent on his behalf. No guidance is provided as to what non-consensual treatments are to be permitted. This cannot be considered sufficiently precise as to satisfy Article

[52] These six lines are actually taken from the discussion of the withholding of H's letters in the original case: see para. 88 of original judgment.

8(2). Admittedly, as the government submits, it may not be possible to draft a law which will definitively determine all eventualities; but equally, it is necessary that appropriate procedures be established and meaningful guidance be provided on matters of substance. The impossibility of perfection in drafting cannot be the excuse for failing to bring about a vast improvement.

The Court therefore finds a violation of Article 8.

109. [87]. The third and last complaint is directed in particular against the psychiatric hospital's practice of sending all the applicant's letters to the curator for him to select which ones to pass on (see paragraph 36 above).